CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

September 4, 1998

S. 2330
Patients' Bill of Rights Act of 1998

As modified by the sponsors

SUMMARY

Title I of the Patients' Bill of Rights Act of 1998 would amend the Employee Retirement Income Security Act (ERISA) to give members of self-insured health plans rights to obtain certain services, require group health plans and health insurance issuers to provide certain information to enrollees and potential enrollees, and establish internal and external review procedures for group health plans and health insurance issuers. Title II would require all health plans, health care providers, and other entities to protect the confidentiality of health information and would allow individuals to inspect and copy their own medical records. Title III would prohibit health plans from discriminating on the basis of genetic information. Title IV would redesignate the Agency for Health Care Policy and Research as the Agency for Healthcare Quality Research and would reauthorize the agency. Title V would authorize or reauthorize various programs of research on women's health and would require health plans to meet certain standards for breast cancer treatment and reconstructive surgery. Title VI would permit carryover of unused benefits in flexible spending accounts, provide for full income tax deductibility of health insurance costs for self-employed individuals, expand the availability of medical savings accounts (MSAs), and establish medical savings accounts under the Federal Employees Health Benefits Program (FEHBP).

The bill would affect the federal budget in several ways. The proposed patient protections, grievance procedures, and standards for breast cancer treatment would increase the premiums for employer-sponsored health insurance, substitute non-taxable fringe benefits for taxable wages, and reduce federal receipts from income and payroll taxes. Permitting carryover of unused benefits in flexible spending accounts, increasing the deductibility of health insurance for the self-employed, and expanding the availability of MSAs would also reduce income tax receipts. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that these provisions would reduce federal tax revenues by $0.5 billion in 1999 and by $7.6 billion over the 1999-2003 period.

The establishment of MSAs in FEHBP would not affect spending in 1999 but would increase FEHBP spending in subsequent years. CBO estimates that the increase in FEHBP spending for annuitants, which is considered mandatory, would amount to $0.4 billion over the 2000-2003 period. The bill would also require additional discretionary spending to implement the research and prevention programs in titles IV and V and to pay for higher FEHBP costs for active federal workers. Subject to appropriation of the necessary amounts, CBO estimates that these discretionary costs would total $1.4 billion in 1999 and $13.8 billion over the 1999-2003 period.

The estimate reflects clarifications and modifications to the bill as specified by the staff of the sponsors. In section 101, the new section 727 of ERISA will be modified to clarify that the preemption of state law would apply only to provisions that establish maximum deductibles that are lower than the amounts specified in the Internal Revenue Code for high deductible health insurance. Section 601 will be modified to eliminate the provision permitting the contribution to MSAs or retirement accounts of unused benefits in flexible spending accounts. Section 604 will be changed to clarify that a catastrophic plan in FEHBP would have a deductible of at least $500 and to include the government's contribution to high deductible/MSA plans in the calculation of the government's contribution to all FEHBP plans.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated effect of the bill on direct spending and receipts is shown in Table 1. The costs of this legislation fall within budget function 550 (health).

BASIS OF ESTIMATE

Revenues and Direct Spending

The proposed rights to medical care and advice, informational requirements, grievance procedures, and standards for breast cancer treatment would affect the federal budget through their effect on premiums for employer-sponsored health insurance. Although the rights to medical advice and care would apply only to self-insured ERISA plans, other plans are likely to be affected by them as well. Federal legislation to regulate a significant part of the health insurance market could stimulate action on the part of both states and health plans to develop consistent policies on coverage. Taking such spillover effects into account, CBO estimates

Table 1. Estimate of the Budgetary Effects of S. 2330, The Patient Protection Act, as modified by sponsors

	By fiscal year, in billions of dollars									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Revenues										
Income and HI Payroll Taxes										
Expand Medical Savings Accounts	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.5	-0.5	-0.6	-0.7
Carryover unused flexible spending account benefits	0	-0.1	-0.3	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2
Full health insurance deduction for self-employed	-0.4	-1.2	-1.2	-1.2	-1.0	-0.6	-0.7	-0.6	-0.3	0
Effect of patient protection provisions	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2
Subtotal	-0.5	-1.6	-1.8	-1.9	-1.6	-1.4	-1.5	-1.5	-1.3	-1.1
Social Security Payroll Taxes	a	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Total	-0.5	-1.6	-1.8	-1.9	-1.7	-1.5	-1.6	-1.6	-1.4	-1.2
Direct Spending										
FEHBP—Annuitants	0	a	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.4
Authorizations of Appropriations										
Title IV—Agency for Healthcare Quality Research	a	0.1	0.2	0.2	0.2	0.2	0.1	a	a	a
Title V, Subtitle A—Women's Health Research at NIH	1.3	3.2	4.0	2.7	0.8	0	0	0	0	0
Title V, Subtitle B—Women's Health at CDC	0.1	0.2	0.2	0.2	0.2	0.1	0	0	0	0
FEHBP—Active Workers	0	a	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.4
Total	1.4	3.5	4.4	3.2	1.3	0.4	0.3	0.3	0.3	0.4

SOURCES: Congressional Budget Office and Joint Committee on Taxation.

NOTES: HI = Hospital Insurance; FEHBP = Federal Employees Health Benefits Program; NIH = National Institutes of Health; CDC = Centers for Disease Control and Prevention.

a. Costs or savings of less than $50 million.

that the provisions for medical care and advice, patient information, grievance procedures, confidentiality of patient information, and breast cancer treatment would raise average premiums by about 0.5 percent. The estimate assumes that about 60 percent of the increase in premiums would be offset through decreases in fringe benefits and that about 40 percent would be passed on to employees as lower wages. JCT estimates that the increase in premiums would reduce federal tax revenues by less than $50 million in 1999 and by $0.5 billion over the 1999-2003 period. Social Security payroll taxes, which are off-budget, account for about $150 million of the five-year total.

The carryover of unused benefits in flexible spending accounts, expansion of medical savings accounts and increased deductibility of health insurance for the self-employed would reduce federal income taxes. JCT estimates that these provisions would reduce federal tax receipts by $0.7 billion in 1999 and by $8.3 billion over the 1999-2003 period.

Right to Medical Advice and Care. Subtitle A of title I contains a number of patient protections for enrollees in self-insured ERISA health plans. Those provisions include a prohibition against interference by health plans with medical communications between physicians and their patients, a requirement that plans pay for hospital emergency visits when the prudent layperson standard is met, a requirement for direct access to an obstetrical and gynecological specialist for covered routine obstetrical and gynecological care, a requirement for direct access to pediatricians for covered routine pediatric services, the right to continue care for 90 days with a provider whose contract has been terminated by a health plan, and a requirement that health plans offer employees a point-of-service option when the existing health plan offerings do not provide choice among provider groups. CBO estimates that these rights to medical care and advice would ultimately increase costs across all nonfederal employer-sponsored health plans by about 0.1 percent.

Informational Requirements. Subtitle B of title I would require all ERISA group health plans to provide certain kinds of information on plan provisions to enrollees and to make other kinds available on request. Most of the required information is typically provided now as part of a plan's handbook or could easily be incorporated into that document. Although some documents would have to be amended to meet the requirements of this provision, such documents are continually changed to reflect new terms. Plans would be responsible for making available to participants any data on quality or performance that they collect, but they would not be required to collect such data. Plans would have to make minor investments in personnel and systems to assure and monitor compliance with those requirements. CBO estimates that the informational requirements would increase costs across all nonfederal employee sponsored health plans by slightly less than 0.1 percent.

Grievance Procedures. Subtitle C of title I would require all ERISA group health plans to abide by specific time limits for making coverage determinations and to have an internal review process for reconsidering coverage decisions within defined time limits at the request of the enrollee. For those coverage decisions involving medical necessity or investigational treatments, a physician with the appropriate expertise would have to conduct the internal review. Plans would also have to provide for external review of medical necessity decisions involving claims for more than $1,000 or investigational treatments for life threatening illnesses. The findings of the external review would be binding on the health plan.

Most plans today have a functioning internal appeals process, but they operate with more flexibility on timing than they might have under this provision. Consequently, a few plans would have to invest in more review personnel to meet the specified time limits. Costs would also increase because of the requirement for external review, which would be new to most plans. CBO estimates that the net cost of this subtitle would be 0.1 percent of employer-sponsored health plan costs.

Confidentiality of Health Information. Title II would require health care providers, health plans, employers, health or life insurers, schools, and universities to provide a patient with access to his or her records and allow the patient to request amendments to the record. These entities, as well as health oversight agencies, public health authorities, and health researchers would have to provide a written statement of their confidentiality policies. Along with law enforcement officials, they would also be required to implement appropriate safeguards to protect the confidentiality of individually identifiable health information.

The provisions regarding access to medical records would impose small administrative costs, most of which could be passed on to the requestor of the information through fees. The requirements for the protection of the confidentiality of health information might impose small costs on entities that do not already have such safeguards in place. CBO estimates that these provisions would increase premiums by less than 0.05 percent.

Genetic Information and Services. Title III would prohibit all health plans and health insurers from using predictive genetic information in setting the premium levels for groups or individual insurance purchasers. It would also prohibit plans from requesting such information except when the information was needed for diagnosis, treatment, or payment relating to the provision of health services. Even then, plans could not require such information and would have to provide the individual with a description of the procedures in place for protecting the confidentiality of such information. Although this provision

would keep health insurers and health plans from reducing their costs through favorable risk selection based on genetic information, its cost to private employer-sponsored health plans as a whole would be negligible.

Standards for Breast Cancer Treatment. Subtitle C of title V would establish standards for breast cancer treatment and reconstructive surgery. Following surgical treatments for breast cancer, health plans and insurance issuers would have to allow the attending physician to determine the patient's length of stay in the hospital. The physician would not have to obtain prior authorization for any length of stay in connection with a mastectomy, lumpectomy, or lymph node dissection for breast cancer. The provisions would also require plans to pay for breast reconstruction for a mastectomy patient, including surgery on a nondiseased breast to produce a symmetrical appearance. CBO estimated that these provisions would add less than 0.05 percent to health plan premiums.

Medical Savings Accounts. The bill would amend the provisions of the Internal Revenue Code governing medical savings accounts to increase the amount of wages, benefits, and investment income given favorable tax treatment and to make these accounts more widely available. Under current law, contributions to an MSA by individuals covered by high-deductible health insurance plans are deductible, and contributions by employers on behalf of the covered individual are excludable for income and payroll tax purposes. Investment earnings of MSAs are excluded from taxable income in the year earned, and withdrawals from MSAs for medical expenses are tax-free.

The proposal would reduce the minimum annual deductible for a high-deductible health insurance policy from $1,500 to $1,000 for an individual policy and from $3,000 to $2,000 for a family policy; these amounts are indexed for inflation. Currently, the amount of the tax deduction allowed for contributions to MSAs is limited to between 60 percent and 75 percent of the annual deductible. The bill would increase the tax deduction to the full amount of the insurance policy's deductible.

S. 2330 would remove the current limit on the number of MSAs and permit all employers to offer MSAs. Workers and annuitants in the Federal Employees Health Benefits Program would also be eligible for high-deductible health insurance with MSAs.

CBO and the Joint Committee on Taxation estimate that enactment of this provision would reduce income and payroll tax revenues by $1.1 billion over the 1999-2003 period.

Offering high-deductible health insurance with MSAs to federal workers and annuitants would increase FEHBP premiums for comprehensive plans by siphoning off relatively healthy enrollees into MSAs. Higher premiums for comprehensive plans, in turn, would increase government contributions for all enrollees. CBO estimates that the availability of the MSA option would also increase the number of workers and annuitants covered by FEHBP—and the associated federal spending—because more workers would participate in FEHBP and fewer annuitants would drop FEHBP coverage upon separation from federal service. Government contributions for annuitants' health insurance are classified as mandatory under the Balanced Budget and Emergency Deficit Control Act; contributions by federal agencies for active workers are discretionary and subject to annual appropriation. CBO estimates that enactment of S. 2330 would raise mandatory federal outlays by $0.4 billion over the 1999-2003 period. Discretionary spending would increase by $0.4 billion, subject to appropriation of the necessary amounts.

Tax Provisions. The bill would permit participants in flexible spending accounts to carry over to later years up to $500 of unused benefits. It would also permit self-employed individuals to deduct the full cost of health insurance. Under current law, the deduction for self-employed individuals will increase from 45 percent of health insurance costs in 1998-2002 to 80 percent in 2006. The Joint Committee on Taxation estimates that these provisions would reduce tax receipts by $5.9 billion over the 1999-2003 period.

Authorizations of Appropriations

Title IV—Healthcare Quality Research. Title IV would redesignate the Agency for Health Care Policy and Research as the Agency for Healthcare Quality Research (AHQR) and respecify its mission. CBO estimates that this title would increase discretionary spending for AHQR by $27 million in fiscal year 1999 and $685 million over the 1999-2003 period, assuming appropriation of the authorized amounts.

The bill would amend and extend the authorization for the Centers for Education and Research on Therapeutics currently run by the Agency for Health Care Policy and Research. This demonstration program provides grants to centers that conduct clinical research to determine and provide objective information on the risks and effectiveness of drugs, biological products, and devices and their new uses. Current law provides authorizations of $2 million in fiscal year 1998 and $3 million for fiscal year 1999. S. 2330 would extend the authorization providing such sums as necessary for fiscal years 2000-2003. CBO estimates that if appropriations are made in the full amount of the authorization, S. 2330 would result

in no additional spending in 1999 and $8 million in additional discretionary spending over the 1999-2003 period.

The legislation would also create the Foundation for Healthcare Quality Research. The foundation would foster public-private partnerships to support the work of AHQR; further collaboration with researchers from universities, industry, and non-profit organizations; and develop linkages with users of healthcare and quality research. The bill would create a committee that would set up the foundation and appoint its initial board members. The committee would terminate within 30 days of completing its designated functions. The Secretary of Health and Human Services would support the foundation through the director of AHQR by grants that would be used solely for administrative expenses. S. 2330 would authorize $500,000 for each fiscal year to operate the committee and up to $500,000 of the Department of Health and Human Services appropriation money to finance grants for the foundation. CBO estimates that this provision would require additional discretionary spending of less than $0.5 million in fiscal year 1999 and a total of $2 million over the 1999-2003 period.

To support all the other activities of AHQR, S. 2330 authorizes $180 million in fiscal year 1999 and such sums as necessary from fiscal years 2000-2003. CBO estimates this would result in a total of $27 million in additional spending in 1999 and a total of $675 million over the 1999-2003 period.

Title V—Women's Health Research and Prevention. Subtitle A would reauthorize several programs and institutes within the National Institutes of Health (NIH) providing such sums as necessary from fiscal years 1997 through 2001. It would reauthorize the National Institute on Aging and the National Cancer Institute. It would also reauthorize programs which perform research on the drug DES, osteoporosis, Paget's disease and related bone disorders, and cancer. Assuming appropriation of the authorized amounts, CBO estimates that reauthorizing these programs would result in additional discretionary spending of $1,236 million in 1999 and $11,408 million over the 1999-2003 period.

In addition, S. 2330 would write into statute a research program within the National Heart Lung and Blood Institute (NHLBI) to expand and coordinate research and related activities of the institute with respect to heart attack, stroke, and other cardiovascular diseases in women. For these activities the bill authorizes such sums as necessary for fiscal years 1999-2001. In 1998 NHLBI spent $173 million on this research. CBO estimates that if spending continued at this level, the bill would result in additional discretionary spending of $51 million in 1999 and $573 million over the 1999-2003 period.

Subtitle B would reauthorize the National Center for Health Statistics (NCHS) and several other programs within the Centers for Disease Control and Prevention. These other programs include the national program of cancer registries, the national breast and cervical cancer early detection program, the centers for research and demonstration of health promotion, and community programs on domestic violence. It authorizes $6 million a year for fiscal years 1998 through 2002 to operate the community programs on domestic violence and authorizes such sums as necessary for fiscal years 1999 through 2002 for NCHS and the remaining programs. Assuming appropriations of the authorized amounts, CBO estimates these provisions would result in additional discretionary spending of $70 million in 1999 and $835 million over the 2000-2003 period.

PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending and receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in Table 2. For purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

Table 2. Summary of Pay-As-You-Go Effects

	By Fiscal Year, in Millions of Dollars									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Change in outlays	0	35	85	130	175	215	250	290	335	385
Change in receipts	-500	-1,600	-1,850	-1,900	-1,700	-1,450	-1,600	-1,600	-1,350	-1,200

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

S. 2330 would preempt certain state health insurance laws that limit the sale of high deductible health plans. This preemption of state regulatory authority would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA). Its impact on the budgets of state, local, or tribal governments would be minimal, however, because the provision would simply limit the application of state law. Therefore, the

threshold established in UMRA ($50 million in 1996, adjusted annually for inflation) would not be exceeded.

The bill would require entities that provide health care services to permit an individual to inspect and copy protected health care information, with some exceptions regarding life and safety issues and confidentiality of external sources. The requirement to provide access would be an intergovernmental mandate for governmental health care providers. However, the cost of providing access to records would likely be minimal. The costs of copying the information could be passed on to the individual.

Finally, the bill's amendments to ERISA and to the Public Health Service Act would establish a number of new requirements governing health care benefits and insurance. However, plans offered by state, local, and tribal governments are exempt from ERISA, and those governments would be able to opt out of the requirements under the Public Health Service Act. Consequently, these provisions would not be intergovernmental mandates as defined by UMRA, and they would have an impact on the budgets of state, local, or tribal governments only if those governments chose to comply.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would impose several private-sector mandates as defined in UMRA. They include the rights to medical care and advice, requirements to safeguard and grant patients access to their medical records, requirements for plans to establish appeals procedures for handling patients' grievances, and standards for breast cancer treatment. CBO estimates that the direct costs of those mandates to private-sector entities would exceed the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation) every year after 1999.

ESTIMATE PREPARED BY:

Federal Cost Estimate: James Baumgardner, Linda Bilheimer,Tom Bradley, Judith Wagner and Amy Weber

Impact on State, Local, and Tribal Governments: Leo Lex

Impact on the Private Sector: Judith Wagner

ESTIMATE APPROVED BY:

Paul N. Van de Water
Assistant Director for Budget Analysis